Healthpoint

Information from the Division of Health Care Finance and Policy

THE LINK BETWEEN EMPLOYMENT AND HEALTH INSURANCE

Most adult Americans under age 65 who have privately purchased health insurance obtain it through their employer or their spouse's employer. Linking health insurance to work began in the 1940s, when firms began to offer insurance in response to a labor shortage and the imposition of a wage freeze by the National War Labor Board during World War II. By 1987, the number of non-elderly Americans covered by employer sponsored plans peaked at 69.2% but declined to 64.2% nationally by 1997[1] and is expected to continue to drop. In 1998, nearly 66% of the insured non-elderly residents of Massachusetts obtained their coverage through work.[2] Americans have become so accustomed to linking health insurance with work that they rarely consider the consequences of relying on employers to purchase their coverage. As the workplace, family, and world economy change, and health care costs continue to rise, however, it is time to examine this uniquely American system of coupling employment and health insurance. This issue of *Healthpoint* looks at the benefits of this system, why fewer people are served by it, and offers policy questions to consider.

Employer Sponsored Health Care Does Many Things Well

Although 41% of adults with employer-based coverage have no choice of health plans,[3] private insurance purchased by employers is almost always less expensive and more comprehensive than private coverage purchased individually. The lower premium price is due to three factors. First, insuring groups spreads the administrative cost of purchasing insurance among many individuals. Second, large organizations obtain better prices. Finally, neither employers nor workers pay taxes on the employer paid portion of insurance premiums and often workers pay their own share with pre-tax dollars.

From the insurer perspective, employees are "natural groups" to insure, coming together for reasons generally unrelated to their need for health services. Both healthy and sick individuals end up in the same risk pool, minimizing adverse selection, thereby facilitating one, more affordable rate.

The job-based system has been effective at bringing relatively healthy individuals into the market and motivating them to obtain coverage by simple payroll deduction. Purchasing health insurance through work has become a common, expected part of the employee-employer relationship. If individuals were left to purchase their own health insurance, no doubt fewer would do so.

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The World Has Changed

Some of the many factors which inexorably led to the declining number of employees obtaining insurance through work include a decrease in union membership (which traditionally lobbies heavily for health insurance benefits), the globalization of the world economy (which pits American made goods against those of other countries whose health care costs are lower), and a shift from manufacturing to service industries (which are less likely to offer health insurance benefits, historically). In addition, passage of the Employment Retirement Income Security Act (ERISA) in 1974 had the unintended but widespread effect of encouraging employers to pay directly the health care claims of their own employees and eligible dependents, rather than to purchase insurance. The self-insurance strategy has become more attractive with the rising number of state mandated benefits and regulations from which self-insured companies are exempt due to federal pre-emption.

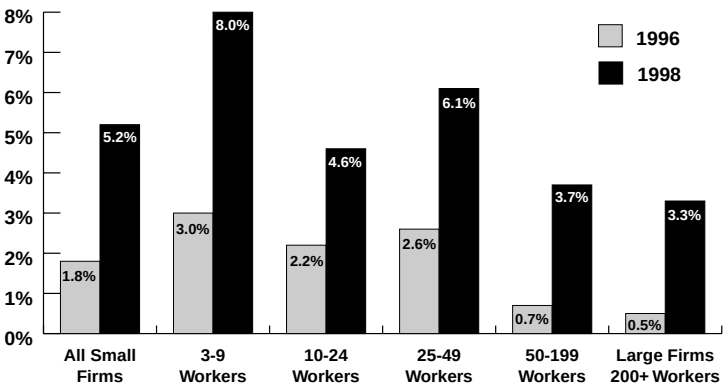
By far the largest factor affecting coverage appears to be the rapid increase in health care costs and associated premiums which have made coverage unaffordable for many. This is not surprising given that the cost of health insurance premiums increased three times faster than wages and salaries from 1987 to 1993.[4]

As the worker share of premiums, copayments and deductibles rises, workers increasingly turn down coverage when offered. In 1998, 17.2% of uninsured working adults in Massachusetts reported that although they were eligible to purchase health insurance through work, they turned it down due to its cost.[5] Most economists believe the employee ultimately pays the entire insurance premium out of his overall compensation regardless of the ratio of premium cost sharing stipulated by a particular employer, as employers have a certain amount of money to spend on employee compensation regardless of how it is parceled into wages, health insurance premiums, vacation pay, pension contributions, etc. While most employees (and unions) resist higher contributions, they should be just as concerned about the rise in the total premium since that consumes compensation dollars. Of course if an employee turns down insurance from an employer who contributes even a small portion of the premium, he rarely receives that foregone compensation in cash.

Shortcomings of an Employer-Based System

Even among covered adults, a significant disadvantage to an employer-based insurance system is that the benefits are not portable from job to job. Some workers experience "job lock"—they are essentially unable to change jobs due to a long insurance waiting period, an exclusion for a pre-existing condition or some other significant disadvantage they would experience in switching to a new employer's health plan. Workers who quit or lose their job can maintain their coverage under the Consolidated Omnibus Budget Reduction Act of 1985 (COBRA), but only for eighteen months and almost al-

Percentage Increase in Premiums Nationally by Firm Size 1996 and 1998



Source: "Health Benefits of Small Employers in 1998."[6]

ways at a much higher cost. Although the federal government has improved portability under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the law applies only in certain circumstances.

Three-quarters of the country's recent job growth occurred in small businesses.[6] Therefore, it is a significant disadvantage that small organizations tend to be charged more per person and experience steeper premium increases for health insurance than large organizations.[7] Even while the economy flourished in Massachusetts between 1996 and 1998, the largest segment of individuals without insurance was employed by firms with less than 50 employees.[8]

Who's Not Covered by the Current System?

The American employment-based health insurance system has done many things well but only for those under its umbrella. It never served well or at all the unemployed; the part time, seasonal, off-the-books or undocumented worker; the self-employed; or the significant other or gay partner of an employee. Recently, the proportion of the population covered as dependents (a traditionally covered group) declined between 1988 and 1995 from 32.3% to 27.8%.[9] All of these groups, including the growing number of workers who have declined employer-based insurance due to rising premiums, have contributed to the swelling number of uninsured in this country. Massachusetts has had partial success in counteracting this trend through MassHealth expansion and other programs.

Policy Considerations

Usually, firms contribute the same amount of money to the health insurance premium of each employee regardless of individual income or tax bracket. Therefore, the after-tax value of the benefit greatly favors the highest wage earners. In Massachusetts, each dollar of health insurance premium is worth $1.72 to an employee in the highest federal and state tax brackets, but only $1.27 to those in the lowest. Were these premiums and related expenses to be treated like cash wages, government would gain an estimated $124.8 billion[10] annually in revenue which theoretically could subsidize premiums for the low-income uninsured. Those who benefit most from the current tax exemption policy on their employer sponsored plans can best afford coverage and probably wouldn't drop it even in the face of a tax on premium contributions. On the other hand, for individuals currently buying non-group coverage on their own, premiums are generally not deductible.

Some shortcomings of employer sponsored coverage already have been addressed by the passage of COBRA and HIPAA, and in Massachusetts, by small-group market reform which somewhat improved access and affordability of coverage for workers in small businesses. As premiums continue to rise, however, we can expect employers to further reduce their contribution or cease to offer coverage. We can also expect more low wage workers to turn down coverage when offered. There are several bills in Congress to facilitate the purchase of insurance by establishing tax credits for, or increasing the deductibility of, health care and premium expenses. In 1999, the Massachusetts Division of Medical Assistance implemented the Insurance Partnership, which provides subsidies to both eligible employers and workers for the purchase of health insurance in an attempt to increase enrollment and discourage employer reliance on Medicaid as an employee safety net.

Some advocate replacing the job-based system with either an individual mandate system or a single payer system. Under the former, individuals would be required to purchase coverage, with a mechanism in place assisting them to do so affordably. However, it is feared that this could lead to a segmentation of the insurance market into healthy and high-need groups leaving few choices for

the latter. In fact, any strong support (through tax credits or subsidies) of individual purchase would attract healthy individuals for the most part. Under the single payer system, government would be the sole purchaser of health care, ensuring access to all, but opponents doubt that government can provide quality health care at affordable prices. Proposals to build a different health care system have received little political support to date for a variety of reasons, but as traditionally covered groups find their cost increasing and choice decreasing, they may add their voice to groups who have long been disadvantaged by the employment-based system.

Endnotes

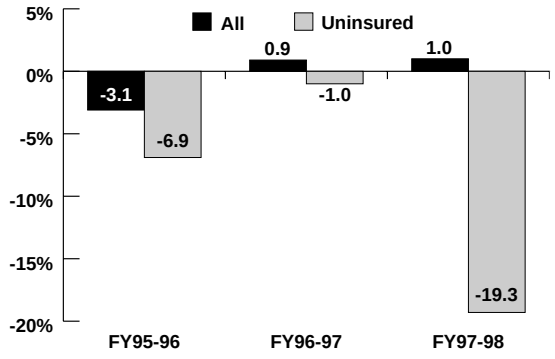
1. Employee Benefit Research Institute (EBRI) estimates from the March 1988-1998 Current Population Survey. Cited in Paul Fronstin, "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion," *EBRI Issue Brief*. Number 211. July, 1999.
2. Division of Health Care Finance and Policy, *Health Insurance Status of Massachusetts Residents*. October, 1998.
3. Employee Benefit Research Institute 1999 Health Insurance Preference Survey. Cited in Paul Fronstin. July, 1999.
4. C. Pemberton and D. Holmes, eds. *EBRI Databook on Employee Benefits* (Washington: Employee Benefit Research Institute, 1995); and U.S. Bureau of the Census, *Statistical Abstract of the United States* (Washington: U.S. Bureau of the Census, 1991 and 1996).
5. Division of Health Care Finance and Policy. *Health Insurance Status of Massachusetts Residents*. October, 1998.
6. Jon Gabel et al. "Health Benefits of Small Employers in 1998." Report prepared for the Henry J. Kaiser Family Foundation. February, 1999.
7. Jon Gabel et al.
8. Division of Health Care Finance and Policy. *Health Insurance Status of Massachusetts Residents*. October, 1998.
9. John Sheils, and L. Alecxih. "Recent Trends in Employer Health Insurance Coverage and Benefits." Washington, DC: The Lewin Group, Inc. 1996.
10. This figure includes foregone taxes due to the health benefits exclusion, the exclusion from reimbursement accounts, the deduction for out-of-pocket health spending, and the exclusion of health benefits from the Social Security and Medicare Hospital Insurance taxes. See Sheils, John and Paul Hogan. "Cost of Tax-Exempt Health Benefits in 1998." *Health Affairs*. 2:18 (March/April 1999): 176-181.

Did you know?

Fewer Uninsured Patients Discharged from Acute Hospitals

Massachusetts uninsured* patient discharges decreased as a percent of all acute care hospital discharges from 6% in FY95 to less than 5% in FY98. The absolute number of discharges for uninsured patients dropped 26% but just 2% for all patients from FY95 to FY98. The dramatic drop from FY97 to FY98 coincides with major MassHealth expansions begun in July 1997. Median and mean charges continue to be lower for uninsured patients who are on average much younger than hospitalized patients overall. Charges for uninsured patients as a percent of all charges decreased from 5% in FY95 to 4% in FY98.

Percent Change in Number of Hospital Discharges



* Expected source of payment recorded as free care or self-pay.
Source: Massachusetts Division of Health Care Finance and Policy hospital discharge data.

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